A SURVEY OF MENTAL HEALTH PROFESSIONALS' AWARENESS OF BLACK ISLANDERS' RELIGIOUS BELIEFS

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By

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APPENDIX F - COPYRIGHT PAGE

THE HEART OF HIM THAT HATH UNDERSTANDING
SEEKETH KNOWLEDGE...Proverbs 15:14

BUT THERE IS A SPIRIT IN MAN:
AND THE INSPIRATION OF THE ALMIGHTY
GIVETH THEM UNDERSTANDING...Job 32:8

ABSTRACT
SCHOOL OF SOCIAL WORK

SIMMONS, SYLVIA M.B. B.A. HAMPTON UNIVERSITY AT HAMPTON VIRGINIA, 1978

A SURVEY OF MENTAL HEALTH PROFESSIONALS' AWARENESS OF BLACK ISLANDERS' RELIGIOUS BELIEFS

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The purpose of this study was to evaluate the awareness of Mental Health Professionals' knowledge of Black islander's religious beliefs. To also determine the educational and training levels of Mental Health Professionals in the area of cross-cultural issues.

Five research questions were tested. The questions addressed the training and educational levels of Mental Health professionals along with their traditional values, if any, as well as the relationship between religion and psychotherapy. The questions also evaluated whether or not Mental Health professionals explored the client's religious belief(s) in therapy. The final area evaluated whether Mental Health professinals believed that understanding a client's culture is important in therapy.

This study used the survey method which is a form of descriptive methodology. Three self-administered instruments were given to a population of 40 Mental Health professionals.

The analysis of the data in this study appeared to warrant the following conclusion:

1. When participants were surveyed, the majority were from the United states. They were black with a Bachelor's degree, married and likely to be employed as nurses. They were reared in small towns and religious preference was Catholic. The median age was between 40 to 49 years.

2. The analysis of the training level of the Mental Health Professional indicated a large percentage never received training in college or while employed in the area of cross cultural counselng.

3. The survey of the issues regarding cultural counseling and religion in therapy indicated a need for training that will benefit the clientele's treatment should be sensitivity and awareness.

4. A large number of the participants agreed that religion and psychotherapy should never be seen as separate but must maintain a working relationship.

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To my husband, Ronald, and my children, Kevin, Jason, and Regina, who were without a wife and mother more times than they want to remember. Thank you for your patience, understanding, love and prayers.

JESUS IS LORD!!

DEDICATION

TO MY FAMILY

RONALD, KEVIN, JASON and REGINA

with God's love and blessings

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CHAPTER I

INTRODUCTION

In recent years, there has been a growing concern in the mental health system as to how effective the provision of therapy is to clients who hold strong beliefs and values. These beliefs and values possessed by clients are usually a reflection of their culture. Culture is defined as, "patterns, explicit, and implicit of and for behavior acquired and transmitted by symbols, constituting the distinctive achievements of human groups...., culture consists of traditional ideas and especially their attached values." (Kroeber and Kluckhohn, 1952). It has been stated that "culture pervades all our lives and forces an active interrelationship between the social milieu and the personality of each individual." (Comas-Diaz and Griffith, 1988).

According to Tseng and McDermott, (1981,p.5-6) "each of us lives within an invisible sheath we call our culture. The sheath has many layers. Some were fashioned by neighborhood, religion, race, and country; others owe their origin to climate and geography. These layers touch each of us, leaving their imprints, sometimes lightly but often indelibly. When a layer becomes too confining, we attempt to cast it off, not always with success, for culture is a pervasive and clinging entity." Tseng and McDermott further state that "culture is far more than behavior or custom. It is also made up of ways of feeling that shape (and are shaped by) ways of doing. Culture is the collective

expression of the group's personality - its wishes, values, and ideology. It is the sum total of knowledge and attitudes, a vast accumulation of ways, of thought, of action, and of emotional expression."

During the past five years, this researcher has worked in various mental health systems as a therapist, providing therapy to clients who hold strong values and beliefs, more specifically, strong religious beliefs. In many cases these beliefs were deeply embedded as a result of their cultural background. Clients shared their frustrations and anger about mental health professionals who labelled them mentally ill, when in fact, their behavior was culturally motivated. As a result of these feelings, observations and interactions with other colleagues, this researcher was prompted to investigate the attitude and behavior of mental health professionals towards a client's religious belief.

The problem as viewed by this researcher was: Can the attitude and behavior of mental health professionals affect the therapy outcome(s) of Black islander clients with religious beliefs?

Purpose of the Study

The purpose of this study was to evaluate the awareness of mental health professionals' knowledge of Black islanders' religious beliefs.

Research Questions

In order to investigate this problem the following research questions were examined in carrying out the purpose of this study.

1. Are mental health professionals trained to deal effectively with the issue of strong religious beliefs when such issues surface in therapy?
2. Do mental health professionals hold traditional religious beliefs/values?
3. Do mental health professionals feel that there is a working relationship between religion and psychotherapy?
4. Do mental health professionals explore the client's religious beliefs in therapy?
5. Do mental health professionals believe that understanding a client's culture is an important factor in therapy?

Conceptual Framework

It is difficult to understand people in isolation. You must understand people according to values, beliefs, group involvement, and culture. Who a person is can best be explained by where he/she comes from. Needless to say, therapists find themselves trying to work effectively with clients outside of their culture. The effectiveness of therapy is linked to the therapist's knowledge of the culture/religious beliefs of his/her client. Griffith (1977) indicated that regardless of the therapeutic orientation, one of the crucial factors in successful therapy seems to be sensitivity to the patient's cultural background.

Comas-Diaz (1981) also indicated that a clinician competent in cross-cultural issues is indeed a competent mental health practitioner.

This society in which we are living is becoming highly pluralistic, and competent therapists in cross-cultural contexts are very much in demand.

The Systems Theory can best be used to describe and analyze human behavior. From this theoretical perspective the individual and his mental health are viewed as a system of actions continuously interacting with self and environment. Gary (1980) indicated that the core of these views of mental health is interaction. It can be argued that mental health and its variations are the result of interaction between and within internal and external action systems and their impact on the individual.

Significance of the Study

Many times when ethnic minorities are used in research, essential factors about them as a people are overlooked. Sue (1981) reported that, "researchers tend to consider their minority subject's view as being an abstract theoretical human condition." He also added that...."A researcher should contribute to the overall intention of the research through the implementation of the study so as to provide new knowledge to the current body of information."

The study was significant in that it would:

1. Assist mental health professionals to provide better services to their clients when strongly held religious beliefs are involved.
2. Provide the higher education system with empirical data that can assist in the addition of subject matter relevant to the social work curriculum.

3. Assist mental health professionals with information about how their values, beliefs, attitude and behavior can interface with their clients' values and beliefs.

4. Provide a better understanding by mental health professionals as to why religion is important to some Black individuals and groups.

5. Assist in increasing awareness of stereotyped attitudes about clients with strong religious beliefs.

6. Provide further information to those mental health professionals are confronted with strong religious beliefs in therapy.

Basic Assumptions

The following assumptions were made in carrying out this study. It was assumed:

1. That the level of knowledge, training and religious experience is very limited in therapeutic treatment by mental health professionals.

2. That religious attitudes of mental health professionals are based on values established early in life.

3. That mental health professionals are frequently not knowledgeable regarding the cultural backgrounds of their clients.

4. That the effects of the study may bring about concern by the Division of Mental Health in the Virgin Islands.

Limitations of the Study

It was felt that the following factors should be considered when generalizations from the findings of this study are made:

1. That since self-reporting instruments were used, it was assumed that the respondents were honest and had accurate recollections when answering the questions on the instruments.

2. That since the focus of this study was on one mental health center in the U.S. Virgin Islands, generalizations should be limited to similar situations.

3. That the values, attitudes, experiences and educational backgrounds of the participants might cause them to respond to the questions in a particular manner.

Definition of Terms

In order to provide a consistent frame of reference for the readers throughout this study, the following are definitions of key terms used in the study.

Attitudes - Are the scores obtained from the Religious Training and Opinion Survey (RTOS), the Religion Scale and the Relation Between Religion and Psychiatry Scale (RBRPS) instrument scale, that are designed to assess participants' attitudes about religion.

Behaviors - Are the scores obtained from the RTOS, The Religion Scale and (RBRPS) instrument scale, that are designed to assess participants' behavior toward religious clients.

Mental Health Professionals - Are those selected to participate in this study who may be catagorized as one of the following: Master's and Bachelor's level Social Workers, Doctorate and Master's level, psychologists, psychiatrists, medical interns, Master and Bachelor's level nurses and licensed practical nurses.

Black Islander Clients - Are those clients who are receiving services at the Division of Mental Health in St. Thomas, US Virgin Islands.

Values - Are scores that were obtained from the RTOS, The Religion Scale and RBRPS scale that are designed to asess participants values about religion.

Evolution of the Problem

Black people have always been religious. Religion is very personal to Black islanders and their experiences. It is deep rooted and the focal point in their common lives. This is true for many Black people throughout the world. Hence, the need for a cross-cultural study cannot be limited to the Caribbean. Through interaction with clients, the mental health system comes in contact with the different cultural beliefs, values and religion. In order to understand what role religion plays in the life of the Black islander it is necessary to understand

the culture of black people in general. Religion has always been important in the life of Black people. Frazier (1963) described the introduction of Christianity as a form of communication used by slave masters to control slaves. There were efforts on the part of the whites to bring the slaves increasingly under the influence of the Christian religion. This was accomplished in part by acquainting the slaves with the Bible. Frazier also noted that the white masters selected parts of the Bible, such as the Lord's Prayer and the Ten Commandments as a means of keeping the slaves in line.

The slaves were taught that the God with whom they became acquainted in the Bible was the ruler of the universe and superior to all gods. They were also taught that the God of the Bible both punished and rewarded Black men as well as white men. The teaching that the Black men received was that if they were obedient, honest and truthful, they would be rewarded in the world after death (Frazier, 1963). Folk healings, root works and spiritualism were so deeply rooted that they influenced the way of thinking of many Blacks. Barrett (1974) expressed, "that it is necessary to understand African culture through religion. Religion for Africans was, is, and ever shall be the source of life and meaning. It is in religion that they live, move, and have their being." He further indicated that, "the hierarchy consists of God, the source of all power, at its apex. The power is distributed in descending order, first to the lesser deities (whose function it is to see that the world of man and things operate smoothly); second, to the ancestors (whose duty it is to see that their descendants carry out the moral precepts handed down to them); third, to the head of the family (the one nearest

to the ancestors); finally to the other members of the family in their order of age and importance (Barrett, 1974).

According to Smith (1981) religion has always been fundamental to the understanding and interpretation of the Black experience. It has enabled a disenfranchised people to hold themselves and their world together. What we may come to see, according to Smith, is that religion has been an indispensable part of Black people's self-affirmation, emancipatory struggles, and quest for ultimate meaning.

Mental health professionals are often confronted with religious materials from their clients. These materials may not be understood as expressed "religious" concerns, but rather as manifestations of a deep-seated pathological condition. Smith (1981) cited J. Herman Blake as saying "good health" among the Black elderly is defined in religious terms. Illness is viewed as the visitation of divine disfavor and good health is viewed as being a sign of divine favor. In these terms medical intervention is perceived as interfering with the driving will and the spiritual quest for wholeness. Blake concluded by saying that illness is viewed as a matter to be worked out between the sufferer and God.

To summarize, Smith (1981) concluded by saying that religion has sustained Black people for centuries; giving them a body of ethical standards and the inner strength to withstand the attacks upon their

public, private and collective selves. Religion became the Black man's purpose, even his destiny. The Black religious experience is something more than a Black patina on a white happening. It is a unique response to a historical occurrence which can never be replicated for any people in America. The Black man's religion was an organizing principle around which his/her life was structured. His/Her church was his/her school; his/her forum; his/her political arena; his/her social club; his/her art gallery; and his/her conservatory of music. His/Her religion was his/her fellowship with man, his audience with God. It was the peculiar sustaining force which gave him/her the strength to endure when endurance gave no promise, and the courage to be creative in the face of his/her own dehumanization (Barrett, 1974). Therefore, it is for this reason that mental health professionals should utilize a cross-cultural approach when working with Black clients. This approach can provide a wider understanding in therapy.

CHAPTER II

REVIEW OF LITERATURE

The review of the literature is organized into sections according to the research questions that are emphasized in this study and for reading continuity. The major sections of this chapter are: (1) characteristics of mental health professionals and Virgin Islanders; (2) cross-cultural training of mental health professionals; (3) values and religious beliefs of clients; and (4) cultural perspective in therapy.

Characteristics of Mental Health Professionals

Mental health professionals for centuries were considered to be physicians. They were depended upon for diagnosis and treatment of persons who were thought to be mentally deranged. Shortly thereafter, physicians became more involved with mental illness, which later developed psychiatry into a recognized specialty of medicine (Group for the Advancement of Psychiatry, 1987).

The development of clinical psychology came out of academic psychology and first became involved in the mental health movement and later in the direct treatment of mentally ill people. Social workers and nurses both gradually began to specialize in mental health issues. As their approach became more professionalized, those professions gained

entry into the mental health field.

Psychiatrists and other mental health professionals identify themselves as generic mental health professionals. Education for this group varies from medical degrees to Ph.D.s. Their functions also vary. Psychiatrists have the legal responsibility for the care of psychiatric patients. A psychologist with a doctorate degree is involved in all of the psychotherapies. The social worker with a master's degree or higher provides all psychotherapy, group therapy, family therapy and consultation to medical and surgical staffs. A nurse's training can vary from a bachelor's or master's degree to a specialty or doctorate degree and includes involvement in psychotherapy (Group for the Advancement of Psychiatry, 1987).

In summary, the mental health professionals have made tremendous impact over the years with technical and applicational services to the mentally ill population. It also appears that specialty is becoming very important in dealing with the mentally ill.

Characteristics of a Virgin Islander

The average Virgin Islander is a mixture of African and European ancestry. Dutch and French are also part of the mixture of the Virgin Islander. Those born in the Virgin Islands or of Virgin Islands parents living in the States refer to themselves as natives. People from Tortola or the British Islands become "natives" after one or two generations, depending upon the degree of their acceptance in the

community (Weinstein, 1962).

People are described as black, brown, red and white, dark and light, but the terms "mulatto" and "negro", with their implications of miscegenation and race, are not often used. Caucasian standards of physical attractiveness prevail, and light skin, straight or wavy hair, and European features are valued as attributes of beauty. Light-skinned children are preferred, as it is felt that such physical qualities will enhance chances for success in life. Historically, skin color has been an important determinant of social position, and wealthier families tend to be of a lighter skinned complexion and therefore more acceptable to the community (Weinstein, 1962).

Weinstein (1962) indicated that social class among native Virgin Islanders is difficult to define in terms of the usual criteria of family, income, occupation, education, place of residence, and church affiliation. Special class was not divided as in the continental United States. In the Virgin Island's society, there is no educated aristocracy of inherited wealth and no group devoted to leisure or philanthropy. There are no society columns in the newspapers, no prominent and exclusive social clubs. The organizations that enjoy the greatest prestige are the Women's League, a civic group, and the Rotary Club. The educational indices of class are also different from those in the continental United States. Some prominent people have not completed a high school education.

The church is probably the most important institution in Virgin Islands society and religious beliefs provide a significant source of identity. A majority of the population belongs to the Anglican, Lutheran, Moravian, and Roman Catholic churches. The few charismatic or "outside" sects have only a small group of followers. For most of the mainline churches the Virgin Islands is still a missionary area and ministers are appointed from the United States. An exception is the Methodist church, which has a minister from the Leeward Islands to minister to its predominantly British West Indian congregation. In the United States social stratification is prevalent where upper-class Negroes go to the Episcopal, Presbyterian, and congregational churches, the middle class to the larger Baptist and Methodist groups, and the lower class joins the small sects. It is also prevalent in the United States that the churches provide leadership in the fight for Blacks' rights, and entry into the ministry is a means of attaining prestige. The churches in the Virgin Islands do not assume this role (Weinstein, 1962).

Obeah, also known as witchcraft, is a religion that originated in Africa and later became dominant in the New World. It was believed that during slavery, the tribe whose witchcraft proved the strongest became the dominant religion of the society. Obeah is used "to tell fortunes or it uses any subtle craft, means or devices by palmistry or otherwise, or pretends to cure injuries or diseases or to intimidate or effect any purpose by means of any charm, incantation or other pretended supernatural practice." It is a sympathetic magic (Dobbin, 1986). It is

also used to treat gout, rheumatism, and venereal disease. Obeah persists because it serves as a model of adaptation to stress. It also structures and expresses the most intense feelings, and organizes what would otherwise be uncontrollable and unpredictable forces (Weinstein, 1962).

Comas-Diaz and Griffith (1988) cited a case study and it goes as follows:

> "Patient A is a 32 year old Black male farm laborer who married at age 27 and during the same year was converted to an Evangelical Christian religion. Within 2 years of his marriage, he started to act strangely, displaying violent outbursts toward his wife. There were marked sexual problems in the marriage and the relationship became more strained. He became excessively religious and aggressive and was admitted by his wife to the Bellevue Mental Hospital. He claimed that nothing was wrong with him although he was displaying features of a paranoid psychosis. He obviously believed that his wife was trying to work obeah on him and that was the cause of leaving the hospital against medical advice, concurring with the patients belief that his wife was working obeah on him to get him out of the way. They took him to an obeah man to receive protection from the evil forces. (p.200-201)

Occupation and economic achievement may form an important basis of identity, but as elsewhere, this varies a great deal with educational and professional levels. Native Virgin Islanders prefer white collar jobs and have an aversion to manual labor, particularly agricultural work. The reason is probably due to the fact that field work reminds them of slavery. The intense desire to own and work land that is present elsewhere in the Caribbean is not marked among Virgin Islanders. Native Virgin Islanders have favored jobs in which the overt prestige value is evident. These include occupations in government service, taxi

drivers, and agents for large European and American business firms. There has been less inclination to work at such well-paying trades as those of plumbers, electricians and carpenters. Small and some large retail stores are more apt to be run by continentals and Puerto Ricans rather than by natives. The occupation of taxi driver has a particular standing. There is a great deal of pride associated with the attaining of a particular job status as opposed to the satisfaction gained from the performance of the work itself or even from the amount of money earned. A larger percentage of the people are employed with the government (Weinstein, 1962).

There are domestic groupings other than the conventional husband-wife-children nucleus that are predominant in the continental United States. Couples find themselves living together as man and wife. There are also many households organized about women and children, from which men are absent or in which they play a minor role. The legal status of parents does not necessarily determine the composition of the household. A man living in the home as a husband or a companion may not be the father of any of the children, although he may have children elsewhere. A married couple may have "outside children" in the home. Some couples marry and have children but for a time continue to live with their respective families, a state of affairs generally attributed to the housing shortage. It is not unusual to find a household where the children bear different or several different surnames. When the children are acknowledged by the father, as they usually are, they take his name, otherwise they have their mother's name. If the mother is married to another man, the child(ren) may take either her maiden name

or her husband's name. The mother of an out-of-wedlock child, if she is young, does not leave her home but continues to live with her family. If her father is not at home, as is frequently the case, or even in some cases when he is, the head of the family is her mother, grandmother, or other female relative. The young girl may look after her own child, or she may go out to work in the islands or to the States, leaving the child to be cared for by her mother. In some households both the girl and her mother may recently have had children. The Virgin Island woman does not separate her personality from the drudgery and monotony of housework as do many women in the continental United States. The American woman's (middle-class) aim is to preserve the health, integrity and prestige of her husband. Virgin Islands women, in the great majority of instances, never quite give up their role of bread winner in deference to their husbands (Weinstein, 1962).

Finally, the language of the people is known as "Calypso". There are no written texts and standard English is taught in the schools. There is some difference between the speech of St. Thomas and St. Croix. Virgin Islanders are vocal rather than verbal, and their speech is repetitive with a rather limited lexicon. The overall impression one gets of the Virgin Islands' dialect is of a rapid, rhythmical speech that sounds so different from standard English, or any other American dialect. Tourists or newcomers often think that the natives are speaking Danish or some exotic West Indian language (Weinstein, 1962).

In summary, Virgin Islanders come from a very unique culture which is a blend of many different cultures. Their strength comes from one

another but most importantly from their belief especially in the church. Even though they are considered U.S. citizens, their mannerisms, practices, beliefs and values set them apart.

Cross-Cultural Training of Mental Health Professionals

Arredondo (1981) traced the origins of cross-cultural counselor education to the emergence and popularity of ethnic awareness and judicial mandates on behalf of minority groups. She also added that the American Psychological Association (APA) has been exerting efforts through psychologists to provide appropriate training in order to work with underserved cultural groups. In 1973, three separate conferences, (Vail, Austin and Dulles) were held to address the failure of clinical and counseling psychologists not meeting the mental health needs of ethnic minority groups. It was further suggested that all professional psychologists require training and continuing education in the special issues of different religious, ethnic, sexual, and economic groups. She also indicated that the Ethical Standards of Psychologists Revision (1979) adopted by the American Psychological Association also addresses the need for cultural sensitivity.

American universities are realizing the need for developing cross-cultural training programs. Cross-cultural courses are required for all students not just those in the specialization. The practicum is providing relevant cross-cultural experiences that enable students to broaden their knowledge base (Arredondo, 1983).

Lefley (1975) introduced seven (7) major issues in training. They are: (1) Is cross-cultural training additive or substitutive? (2) How do we overcome theoretical and conceptual barriers to cross-cultural training? (3) How do we overcome institutional barriers to training? (4) Who is to be trained and at what level? (5) What is to be taught? (6) How do we distinguish the domains of socio-economic minority, migrant, and acculturation status from that which is purely ethnocultural? (7) Can the usefulness of cross-cultural training be demonstrated empirically? and, how do we evaluate its relevance to a positive outcome in the field?

These questions are needed to demonstrate that cultural education is not merely an elective addition to one's existing corpus of skills but indeed may be the most vital component in developing the truly effective counselor or psychotherapist (Lefley, 1975).

Training approaches have been developed for the purpose of preparing counselors to work with culturally different clients. Peterson (1981) stated that there has been no systematic development of methods toward a theoretical basis, no comparisons of training outcomes, and no agreed upon outcome criteria. He then concluded by saying "it is not surprising therefore that skills-training models adapted for preparing counselors to work effectively in any one culture are likely to fail in a multicultural setting." He concluded by saying "that training approaches can be divided into those emphasizing culturally specific knowledge or skills related to the unique values of a

particular culture and those emphasizing culturally generalized aspects that would apply in any contrasting culture."

In summary, cross-cultural training for mental health professionals is becoming a rapidly growing area of concern. It is almost impossible to conduct any type of therapy/counseling without cultural sensitivity. The knowledge and understanding of culture in therapy are becoming essential factors in providing effective therapy. Training in cultural diversity is becoming essential for professionals in the mental health field.

Values and Religious Beliefs

According to Swensen (1981) the philosophical and theological roots of religion are our whole way of looking at man/woman and life. He felt that we have continued to proceed as though those roots had no implications for receded current practice. But as these roots have receded into history and become forgotten, we have had to learn anew that the problems to which our philosophical and theological past addressed themselves are still very much with us. So now we find ourselves having to address them again.

The problem of dealing with religion is not identical to the problem of values in psychotherapy, but is closely related to it. Religion is the source of values. The basic values on which a person bases life and the decisions of life may be considered to be that person's religion. Swenson (1981) cited Peck (1978) as saying, that

everyone has some explicit or implicit view of the nature of human existence, and that this view is the person's religion. He advised psychotherapists to "find out your patients religion even if they say they don't have any." Since religion, a person's basic view of human nature, would seem to be a matter of considerable importance, it seems rather strange that psychotherapy has managed to avoid it for so long.

Beuther (1979) was also cited by Swenson (1981) who demonstrated the importance of values in psychotherapy. His review of the literature concludes that improvement in psychotherapy is significantly correlated with a change in values. Furthermore, this change in values in patients who improve is in the direction of increased agreement with the therapist's values. He concluded by saying, "it is apparent that very personal and religious values are implicated in the therapeutic change process."

Swenson (1981) cited several clinical experiences on religious issues in psychotherapy. "There are the purely religious issues in which a person's explicit religious beliefs are directly involved in the problem(s) the patient brings to psychotherapy. An example of this was a 26-year old woman who was raised in an Orthodox Jewish home. She married a Christian man, and converted to Christianity. The basic problem she presented was one of low self-esteem in which she could not accept herself, so she could not believe that God accepted her. In a sense, this woman felt that she could not worship a God who could not

accept her. A similar problem was presented by a 30-year old man whose wife had left him to live with another man. She subsequently divorced him and married the man she was living with. His problem was that his religious beliefs did not allow divorce. How could he reconcile his religious beliefs with his situation in life.

Swenson's (1981) solution for such problems suggests that some change is required in the fundamental view that these patients have of themselves and of their relationship with and to God. It is then important for mental health professionals to take note of their own values and not let those interfere with outcomes.

Another kind of problem is conflict between the therapeutic method itself and the basic beliefs of the patient. This was illustrated by a case in which the patient was a Jehovah's Witness. The patient held an administrative job in which he was subject to considerable stress. He was taught a relaxation and meditation technique as a way of coping with the stress. This technique was derived from transcendental meditation, and therefore was at variance with his own religious beliefs. The therapist became concerned that the patient might discover the origin of the technique, and this conflict became an additional problem of the patient who had supervisory responsibilities. There was the conflict between this religious belief that he should be meek and the assertion training prescribed to help him cope more effectively with his subordinates and colleagues (Swenson, 1981).

A third kind of problem cited is a conflict between the patients values and the therapist's values. This conflict may be one in which the patient is behaving in a way that violates the therapist's values or conversely the patient feels guilty about a behavior that the therapist believes should not be a problem. An example of this kind of conflict was a man who was divorcing his wife. He had found a copy of her diary in which she wrote about a lesbian affair she was having. He xeroxed copies of her diary and gave them to his lawyer to use in the divorce suit. The therapist felt that this behavior on the part of the patient was unethical. An example of a problem that the therapist does not feel was a problem that involved a middle aged woman who was being treated for anxiety and depression. Her anxiety and depression were directly related to the behavior of her two college-aged daughters and her relationships with them. She felt that salvation depended upon a particular kind of religious practice. She had raised her daughters to follow the practices and teachings of her church. However, her daughters, now that they had become independent, had developed religious ideas of their own that were at variance with the beliefs of their mother. The mother was distraught because she feared her daughters would end up going to hell, but she was also deeply distressed because she felt that she had always been close to her daughters, and her relationship with them meant a great deal to her, but their religious differences had estranged them.

It is Swenson's (1981) opinion that religion and values are of importance to psychotherapy and demonstrate that religious issues do arise in psychotherapy. He felt that the incorporation of religion and values can enhance the effectiveness of psychotherapy. The most basic values of a person are concerned with the nature of humanity, the universe and the purpose of life. These values permeate every aspect of a person's life and directly produce, in turn, the values by which the person lives day-to-day. Engaging these values in the therapeutic enterprise should increase the effectiveness of the enterprise.

In summary, the literature clearly indicates that values of clients are very important and should not be overlooked. Therapists and mental health professionals must recognize their own values and not impose these values on their clients. It is important to point out that religion is an important factor in the lives of so many people. It is therefore essential for therapists to become aware of their own biases in order to assess the significance of religious belief in the lives of their clients. This unbiased assessment can be necessary in providing effective therapy.

Cultural Perspective In Therapy

Lonner and Sundberg (1981) have written extensively in the area of assessment in cross-cultural counseling and therapy. They indicated that the counselor-client "mix" can be diverse. They pointed out that

most large countries are multi-racial and multi-ethnic. White Americans often work with Blacks who speak a dialect and live in a special culture, but counseling and other human service work also cut across national boundaries. Professionals are faced with the problem of trying to assess others who have different living patterns, language usages, and values as well as different expectations and social supports with respect to solving personal problems or adjusting to situational problems. It is therefore the overall goal in assessment for the counselor to minimize ethnocentrism and maximize useful and culturally appropriate information.

Diagnosis is looked upon as an assessment issue. To test or assess usually means that the person being tested is put into a specific category, through the use of the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders (DSM:III). The use of any classification system can, at times, provide inaccurate diagnosis and can result in potentially tragic consequences. Once a false label is attached to an individual through improper use of diagnosis, it may stereotype and encumber someone with an inaccurate attribution of a psychological deficit (Lonner and Sundberg, 1981).

In counseling and psychotherapy, assessment begins the instant contact between counselor and client is first made. Information gathering about and from a client can be obtained from dialogue and observation (Lonner and Sundberg, 1981). A therapist's effectiveness

depends on his/her perceived credibility. No matter what the therapeutic orientation, one of the crucial factors in successful therapy seems to be the therapist's understanding and sensitivity to the patient's ethnocultural background.

Comas-Diaz (1981) stated that cross-cultural mental health treatment is recognized more and more as a genuine specialty area. The more pluralistic our society becomes, the more the demand for mental health professionals who competently address a multicultural context. Cross-cultural mental health treatment can be used in a wide range of circumstances. The treatment technique can be effective in helping chronic illness with its source in a certain culture. Sensitivity, understanding and competence in multicultural contexts benefit not only the culturally different patient but the clinician as well. Allen (1985) saw the need to engage patients before entering therapy. By engaging the patient, you are simply preparing the patient for therapy. He came up with 12 commandments or rules that are necessary for engaging the patients.

Allen (1985) listed twelve (12) Commandments that are necessary in engaging the patients:

1. Do not assume that he or she is absolutely likely or unlikely to have any particular life problem, personality disorder, illness, mode of presentation or attitude to therapy; that is, do not stereotype the patient. For example, despite the frequent nature of dependency traits, obsessional personality features are not uncommon especially to socially mobile and upper-income patients.

2. Assess the patient's understanding of psychiatry and psychotherapy, as well as to what extent he or she was adequately prepared by the referring agent. Try to understand the model the patient is using as well as the degrees of contribution of cultural conditioning and intrapsychic defenses.

3. Given the fact that the human being is a unity of the biological, psychological, social, spiritual, and political, once a proper clinical assessment is made, it is possible to begin with the validity and needs conveyed by the patient's understanding. Then one can help him or her to make the link between nonpsychological and psychological models if possible. The author has found the use of diagrams, day-to-day examples, and experiential demonstrations very useful.

4. As well as doing a conventional history and mental status assessment, try to assess the sociocultural influences, socialization patterns, and culturally determined adaptive traits that have operated at the patient's particular point on the color-class spectrum.

5. Approach cultural issues cautiously but advisedly while assessing the cultural awareness, openness, flexibility, general defensiveness, and other ego strengths of the patient. Share your interest in and knowledge of the patient's culture or subculture and seek to be taught by him or her. This step very much applies to West Indian therapists treating patients in color-class-ethnic groupings other than their own.

6. Avoid being judgmental and show respect for the strengths of the patient's cultural background. Also avoid being condescending, overenthusiastic, phony, and prescribing.

7. Utilize a degree of formality, depending on the cultural relatedness and counderstanding that develop between yourself and the patient. Given the British influence and West Indians' concern about respect, it is best to start with a warm but formal attitude.

8. Relate to the strong religious worldview that many West Indians hold, even when they may not be active in a church. Some will feel inadequately helped if the relevant issues they raise are ignored or confronted with a nonreligious therapist's neutrality. Suggesting the help of a member of the clergy is appropriate. Be prepared to elicit tactfully information about the use of and views relating to nontraditional healers.

9. Remember that many West Indian territories have their own dialects that are valid language forms used to express their rich cultural heritage and deep emotions. Getting to know and

sometimes share significant expressions can aid empathy and understanding. Books such as Jamaica Talk (Cassidy, 1961) are helpful, as well as novels and folklore literature.

10. The retarding influence of value confusions, historical role deprivation, and authoritarianism on communication between spouses and across generations has been discussed. As one tries to deal with these problems in marital and family therapy it is sometimes useful to allow the parties to overcome a fear of losing face by separately ventilating their grievances, exploring their values and roles, and discovering means of conflict resolution.

11. In dealing with psychotic patients, especially where the picture looks atypical, look for the meaning and the form in terms of factors such as cultural confusion, stresses, coping mechanisms, a well as secondary gain.

12. With migrants and those wishing to return home, determine their reasons and expectations for change of country of residence. Be careful about suggesting returning home as a solution to adjustment problems (127).

In summary, therapists must always continually conduct self-awareness that will prevent prejudicial and stereotypical behavior. It is becoming essential for therapists to look at their own self-knowledge about the different counseling processes. This self-knowledge can provide the therapist with qualities of understanding, sensitivity, and cultural awareness that are essentially important in treating the cultural client. Therapists should be culturally sensitive, respectful, understanding and informed with the cultural background of their clients. A therapist who finds himself or herself astute and competent in cross-cultural issues, can find himself/herself better equipped to deal with cultural issues in therapy.

CHAPTER III

METHODOLOGY

The methodology and procedural steps that were used in carrying out this research study are outlined in this chapter. The chapter is arranged as follows: (1) Research Design; (2) Population; (3) Instrument; (4) Validation Procedures; (5) Assessment Procedures; (6) Procedures for Implementation; (7) Analysis of Data.

Research Design

The research design utilized in this study was a survey, which is a form of descriptive methodology. Survey procedures are employed to determine the current status of phenomena. According to Ary et al. (1972) the steps employed in descriptive research are: (1) Statement of the Problem; (2) Identification of information needed to solve the problem; (3) Selection or development of instruments for gathering data; (4) Identification of the target population and determination of any necessary sampling procedure: (5) Design of the procedure for data collection; (6) Collection of data; (7) Preparation of the report.

Descriptive research techniques allow the researcher to obtain information concerning the current status of the attitudes and behaviors of mental health professionals toward Black islanders who hold strong

religious beliefs. It aimed to describe what existed with respect to variables or conditions in the situation.

Population

The population for this study consisted of 40 mental health professionals who are providing direct therapeutic services to mentally ill Black Islanders at the Division of Mental Health in the United States Virgin Islands. These mental health professionals may be categorized as follows: Master's and Bachelor's level Social Worker; Doctorate and Master's level Psychologist, Psychiatrist; medical interns, Master's and Bachelor's level nurses and Licensed Practice Nurses.

The staff at the Division of Mental Health comes from diverse backgrounds. A large percentage of the staff comes from the mainland (United States). A few come from neighboring islands and a small percentage come from the Virgin Islands. The educational background of these persons vary from high school graduation to doctoral and medical achievement. Religious training and experience vary significantly with individuals. Some staff members have been exposed to some religious or cross cultural training while other staff members have not.

Setting

The United States Virgin Islands is comprised of three islands, St. Thomas, St. Croix and St. John. The three islands total an area of about 133 square miles. St. Croix is the largest, St. Thomas second,

and St. John is the smallest of the islands. The population of the Virgin Islands is comprised of a diverse mixture of people, i.e., Danish, descendants of African slaves, European, Portugese, French, West Indies, Puerto Ricans and people from the U.S. mainland. The racial composition of the Virgin Islands is predominantly Black. The various levels of formal educational attainment range from no formal education to graduate and medical degrees. (See Review of Literature for further description of the population).

The Division of Mental Health is located in the rural area of the Island of St. Thomas. It was established to provide Mental Health Services to the community of the three (3) islands. Approximately 1836 clients are served yearly by the division. The three (3) main services that the division provides for the clients are substance abuse, child care and mental health. The composition of the clients is about seventy-five percent Black West Indians; Hispanics are ten to fifteen percent; and five to ten percent fall in the category of other. The religious practice of clients varies from Lutheran (which appears to be one of the dominant religions) Catholic, and Methodist. Obeah, witchcraft or voodoo is looked upon as a religious practice which clients sometime engage in on a regular basis. Seventy-five to eighty percent of the clients are unemployed and of this percentage 45 percent are indigent. Of those employed, the average income is about $4,000 annually. The educational level ranges from no formal education to a college degree.

Instruments

The instruments that were used in this study are the Relation between Religion and Psychiatry Scale (RBRPS), The Religion Scale and the Religious Training and Opinion Survey (RTOS) (See Appendix A). The completion of the questions took approximately thirty minutes.

The RBRPS scale was developed by Webb and Kobler (1961), using a combined Thurstone and Likert method. It measures only one side of the possible conflict between psychiatry and religion: Negative statements are all in terms of rejection of psychiatry because of religious conviction. There are no negative statements rejecting religion because of psychiatric convictions. All positive items emphasize the compatibility of these two approaches to man/woman. In short, it measures the degree to which religion is seen as compatible with psychiatry (Shaw and Wright, 1962).

Subjects: The sample on which the scale was originally developed was made up of 268 Catholic seminarians.

Reliability: The test-retest reliability coefficient for a two-week retest interval was .93. A split-half reliability estimate of .95 is also reported by the authors.

Validity: Validity was established through the prediction of known groups. The scale is probably restricted in its validity to use with

samples possessing religious convictions.

The Religion Scale

Description: This is a 25-item Likert-type scale developed by Bardis (1961). It measures positively, attitude toward religious faith and other religious referents.

Subject: Subjects included 324 members of various religious faiths, ministerrial students, agnostics, and college students.

Reliability: Bardis (1961) reports a split-half reliability of 90 based upon 10 to 130. He also reports test-retest reliabilities of .94, and is based upon a sample of 52 subjects.

Validity: The scale is reported by the author to differentiate between agnostics and religious persons and between ministerial and non-ministerial students. The items were selected to discriminate between high and low scores. The items sample the content domain of acceptance, religious teachings and positively valuing religion. The large number of items collected originally and the variety of sources should provide a degree of content validity.

Religious Training and Opinion Survey (RTOS)

This instrument was developed by the researcher for the purpose of assessing participants' training and opinions about religion in therapy.

The survey itself consists of 12 self-report items which the respondent is asked to answer as truthfully as possible. In selecting the 12 items for inclusion in the survey, the researcher attempted to include those behaviors which were cited in the literature.

Items 1, 2 and 3 refer to training in religious issues as well as cross-cultural training; items 4 through 7 focus on clients' religious concern in therapy; and items 8-12 deal with whether a therapist would seek the assistance of a priest/pastor. These items also address the therapists feeling about the assistance sought.

Validation Procedure

In order to establish a degree of reliability and validity a feasibility study was conducted involving the instrument(s) which the researcher developed. The mental health professionals who were selected for the feasibility study were from a local hospital. These subjects were not involved in the study. The subjects were chosen because of their similarity to the research population relative to race, education and training (See Appendix A).

Validity - The instrument(s) was examined and rated by a panel of three (3) judges consisting of two (2) doctoral level social workers and one (1) sociologist. Each judge was provided with a copy of the instrument(s) and a rating scale. They were asked to rate the instrument on content, form, clarity of items, vocabulary and

directions. A Likert type scale was used to rate the instrument(s) using a five (5) point code, with one being low and five being high. The researcher solicited recommendations and comments. The results were used to determine the percent of agreement. For instruments of this kind .85, is considered appropriate. The comments were evaluated and, where feasible, were incorporated into the final version of the instrument.

Table 1

Results of Judges Ratings

JUDGE	RACE	SEX	#1	#2	#3	#4	#5	#6	MEAN
Judge 1	B	F	2	2	2	3	2	2	2.1
Judge 2	B	M	2	2	2	2	1	2	1.8
Judge 3	B	M	2	2	2	3	1	2	1.6
MEAN			2	2	2	2.7	1.3	2	2.0

CODE

1 = I strongly agree with statement

2 = I agree with the statement

3 = I am undecided about the statement

4 = I do not agree with the statement

5 = I strongly disagree with the statement

The percent of agreement among the three representatives was .89, which was close to the expected percent of agreement (.85) for instruments of this kind. Results of the rating from the Feasibility Study can be found in Appendix A.

Procedure for Implementation

The following procedural steps were employed in implementing this study.

1. Secure authorization from the Assistant Commissioner of the Division of Mental Health to conduct study.
2. Approval of the proposal was secured from the faculty of Atlanta University School of Social Work.
3. The population was selected.
4. Informed consent letter was provided to the participants prior to the onset of the study, indicating their willingness to participate in the study.
5. A schedule for conducting the interviews was developed and approved. The time, place, and date were agreed upon by the participants and the interviewer.
6. The Relation Between Religion and Psychiatry Scale, the Religious Scale and the Religious Training and Opinion Survey were administered following orientation sessions with the participants.
7. Data were organized, analyzed, interpreted and reported.
8. Findings, conclusions, implications, and recommendations were incorporated into the final dissertation.

Analysis of Data

The data that were used in this study were collected and statistically treated in the following manner:

1. The survey instruments: The Relation between Religion and Psychiatry Scale, the Religion Scale and the Religious Training and Opinion Survey. These three (3) instruments were utilizing structure interview and self-reporting procedure: The completed instruments were returned to researcher. Any incompleted instruments were returned to the participants and upon completion given to the unit leader who will mail them to the researcher.

2. Simple percentage and correlational procedures were used where feasible to analyze, describe and interpret the data.

3. Tables, charts and graphs were used to array data.

Chapter 4

RESULTS AND DISCUSSION

This chapter presents the results of the statistical analysis, interpretation of data, and discussion relevant to this study.

Statistical Analysis

The results of the statistical analysis of the data were presented according to six catagories. These categories are (1) demographics (characteristics), (2) training of Mental Health Professionals, (3) traditional values of Mental Health Professionals, (4) Religion vs Psychotherapy, (5) Religious beliefs in therapy, and (6) understanding client's culture in therapy. The research questions were divided based on the manner in which they were originally stated in Chapter one and on the nature of the data to be presented. The original sample consisted of forty subjects who were provided with three self report instruments. Statistical and interpretation data regarding the subjects have been included.

Characteristics of Mental Health Professionals

Under the category of characteristics of Mental Health Professionals, Table 2 provided a general description of the participants.

Table 2

Characteristics of Mental Health Professionals
(N = 40)

Characteristics	Frequency	Percent
Sex		
Male	7	17.5
Female	33	82.5
Race		
Black	30	75.0
White	9	22.5
Hispanic	1	2.5
Marital Status		
Married	24	60.0
Single	6	15.0
Divorced	8	20.0
Separated	0	0.0
Widowed	2	5.0
Profession		
Psychiatrist	2	5.0
Psychologist	4	10.0
Social Worker	10	25.0
Nurse	13	32.5
Mental Health Worker I & II (including counselors, substance Abuse counselors, etc)	10	25.0
Aide	1	2.5
Educational Training		
High School	5	12.5
Associate Degree	3	7.5
Bachelor's Degree	17	42.5
Master's Degree	12	30.0
M.D.	1	2.5
Ph. D	1	2.5
No response	1	2.5
Place of Birth		
United States	20	50.0
Virgin Islands	9	22.5
West Indies	8	20.0
Europe	3	7.5

Table 2 cont.

Characteristics	Frequency	Percent
Length of Experience (Clinical Mental Health Services)		
2 year or less	5	12.5
2 to 5 years	4	10.0
5 to 10 years	10	25.0
10 to 15 years	9	22.5
More than 15 years	12	30.0
Place of upbringing (rearing)		
Small town	16	40.0
Suburban	4	10.0
Rural	4	10.0
Mid-size town	9	22.5
Large city	5	12.5
No response	2	5.0
Age		
20 to 29	3	7.5
30 to 39	6	15.0
40 to 49	17	42.5
50 to 59	10	25.0
60 or older	4	10.0
Religious Preference		
Catholic	9	22.5
Anglican	7	17.5
Methodist	3	7.5
Moravian	1	2.5
Lutheran	5	12.5
Baptist	5	12.5
Protestant	1	2.5
Bahai	3	7.5
Islam	1	2.5
Hebrew	1	2.5
Israelite	1	2.5
Seven Day Adventist	1	2.5
No preference	2	5.0

Source: Cultural and Religion Scale

The results of Table 2 indicated that the typical individual who participated was female (82.5%), married (60.0%), nurses (32.5%), Black

(75.0%), born in the United States (50.0%), catholic (22.5%), reared in a small town (40.0%) and had a Bachelor's degree (42.5%). The median age was between 40 to 49 years old (42.5).

Scoring of Religion Scale and RBRPS

The religion scale was designed so that high numerical scores indicated a strong traditional religious and more conservative attitude towards religious beliefs. Low numerical scores indicated a none traditional religious value and more a liberal attitude towards religious beliefs.

The RBRPS was designed so that a high numerical scores indicated an individual's belief that religion and psychotherapy are not compatible. While lower scores indicated a belief in the compatibility of religion and psychotherapy.

Training of Mental Health Professionals

Under the category of training of Mental Health Professionals, research question one was designed to assess the level of training in the area of cross-cultural counseling, value, therapy and religious philosophy of the subjects who participated in the study. The results of the analysis of the data relative to professional training effectiveness in dealing with strong religious beliefs that surface in therapy are shown in Tables 3a, 3b, and 3c respectively.

Research Question One

Are Mental Health Professionals trained to deal effectively with the issue of strong religious beliefs when the issue surfaces during therapy?

Table 3a

Religion and Cross-Cultural Training
(N=40)

ITEM(S)	DESCRIPTION		RESPONSE PATTERN YES	NO
1	Have you been trained in religious issues	f	10	30
		%	25.0	75.0
2	Did your school provide cross-cultural training	f	5	35
		%	12.5	87.5

Source: Religion Training and Opinion Survey (RTOS)

Table 3a shows the results of the data analysis related to the difference between the percentage levels for those Mental Health Professionals (trained or untrained) to deal with the issue of strong religious beliefs in therapy. Seventy five percent (75.0%) of the Mental health Professionals, who participated in the study have never received training in religious issues. Training in the area of cross-cultural dynamics was also not provided to the majority of Mental Health Professionals during their educational experience.

Table 3b

Professional Training

Item(s)	Descprition	Response Patterns			
		Yes	Percent	No	Percent
4	Have you had professional training in:				
a.	Cross-cultural counseling	14	35.0	26	65.0
b.	Value System theory	12	30.0	28	70.0
c.	Religion/Philosophy	10	25.0	30	75.0

Source: The Culture and Religion Scale

Table 3b shows the results of data analysis related to the difference between the percentage levels of professional training obtained by Mental Health Professionals. The table reflects that a large percentage of Mental Health Professionals have not received cross-cultural, value system or religion philosophy training.

Table 3c

Professional Training and beliefs in Therapy
(N=40)

ITEM(S)	DESCRIPTION		RESPONSE PATTERNS				
			SA	A	UNDECIDED	DA	SDA
15	Training in religion is essential in order to relate to clients.	f	3	10	12	11	4
		%	7.5	25.0	30	27.5	10.0
17	Cross-cultural training is essential in psychotherapy.	f	5	20	9	4	2
		%	12.5	50.0	22.5	10.0	5.0
39	Mental Health Professionals should receive cross-cultural training when working in a cultural area.	f	10	20	8	2	0
		%	25.0	50.0	20.0	5.0	0.0

Source: The Relation between Religion and Psychiatry Scale

Table 3c shows the results of the data analysis related to the differences between the percentage concerning the level of training in religion and cross-culture. About half of the participants (62.5%) indicated that cross-cultural training is essential in psychotherapy. It was also indicated that Mental Health Professionals (75.0%) should receive cross-cultural training when working in a culturally.

Summary:

Research question one comprising the category of training of Mental Health Professionals was significant in the findings. These results indicated that Mental Health Professionals expressed that training in cross-cultural and religion was essential, when working in a culturally sensitive area. The results clearly stated that Mental Health Professionals indicated that they did not receive training before or after being employed in cross-cultural religion/philosophy or value theory.

Traditional Religious Beliefs/Values

The results of the analysis of data relative to whether Mental Health Professionals hold traditional religious beliefs/values are shown in tables 4a and 4b. Table 4b attempted to be more specific in considering selecting traditional value items from the survey. Only those items that dealt with traditional statements were evaluated.

Research Question Two

Do Mental Health Professionals hold traditional religious Beliefs/-Values?

Table 4a

Traditional religious Beliefs/Values of Mental Health Professionals (N=40)

Item(s)	Description	Response Pattern Frequency	Percentage
Traditional	Do Mental Health Professinals hold traditional religious Beliefs/Values?	21	52.5
Non Traditional		19	47.5

Source: The Religion Scale

Table 4a shows the results of the data analysis related to the percentage of Mental Health Professionals who hold traditional values. Based on a scale of 25 to 125, fifty two percent (52.0%) indicated that they hold traditional values. However forty seven percent indicated that they hold non traditional values; which was only a marginal difference from those with traditional values.

Table 4b

Traditional Values (N=40)

ITEM(S)	DESCRIPTION		RESPONSE PATTERNS SD	DA	UNDECIDED	A	SA
4	People should attend church once a week, if possible.	f	1	9	7	17	6
		%	2.5	22.5	17.5	42.5	15.0

Table 4b cont.

Traditional Values
(N=40)

ITEM(S)	DESCRIPTION		RESPONSE PATTERNS SD	DA	UNDECIDED	A	SA
5	Belief in God makes life more meaningful.	f	0	0	1	15	24
		%	0	0	2.5	37.5	60.0
8	People attending church regularly develop a sound philosophy.	f	2	16	9	10	3
		%	5.0	40.0	22.5	25.0	7.5
9	We should always love our enemies.	f	4	6	10	17	3
		%	6.0	15.0	25.0	42.5	7.5
10	God rewards those who live religiously.	f	1	6	15	12	6
		%	2.5	15.0	37.5	30.0	15.0
11	Prayer can solve many problems.	f	0	3	2	22	13
		%	0.0	7.5	5.0	55.0	32.5

Source: The Religion Scale

Table 4b shows the results of the data analysis related to the difference between the percentage levels for those Mental Health Professionals who hold traditional values. Eighty-seven (87.5%) of the participants indicated that prayer can solve many problems.

Summary

In the category of traditional values Mental Health Professionals showed some interesting results. The results indicated that traditional and non traditional values held by Mental Health Professionals showed no significant distinction between them. However, when an examination of specific items from the survey were made, the results showed a definite difference based on the responses. According to the tables presented, a large percentage agreed with a majority of the statements. Based on the findings, it is safe to assume that Mental Health Professionals do hold traditional religious beliefs and values.

Research Question Three

Do Mental Health Professionals feel that there is a working relationship between religion and psychotherapy?

Table 5

Relationship between Religion and Psychiatry
(N=40)

ITEM(S)	DESCRIPTION		RESPONSE PATTERN				
			SA	A	UNDECIDED	DA	SDA
1	There is a close relationship between religious and psychological concepts.	f	2	15	15	8	0
		%	5.0	37.5	37.5	20.0	0.0
7	There is no conflict between psychotherapy and religion.	f	2	16	11	8	3
		%	5.0	40.0	27.5	20.0	7.5

Table 5 cont.

Relationship between Religion and Psychiatry
(N=40)

ITEM(S)	DESCRIPTION		RESPONSE PATTERN				
			SA	A	UNDECIDED	DA	SDA
14	Religion and Psycho-therapy are compatible	f	1	16	18	4	1
		%	2.5	40.0	45.0	10.0	2.5
32	Psychotherapy, because of its exclusive concern with abnormal individuals is of little use to the minister/pastor.	f	1	2	9	24	4
		%	2.5	5.0	22.5	60.0	10.0
38	A pastor/minister should not hesitate to refer a church member to a psycho-therapist.	f	4	27	8	1	0
		%	10.0	67.5	20.0	2.5	0.0

Source: The Relation between Religion and Psychiatry Scale

Table 5 shows the results of the data analysis related to the difference between the percentage concerning the relationship between religion and psychotherapy. Forty-two percent (42.5%) of the participants felt that there is a relationship between religion and psychology. When asked if religion and psychotherapy are compatible, Forty-two percent (42.5%) agreed.

Relationship between Religion and Psychotherapy

The Results of the analysis of data relative to the relationship between religion and psychotherapy is shown in Table 5.

Summary:

Research question three comprising the category of the working relationship between religion and psychotherapy indicated that a significant number felt that there was a relationship. These results indicated that Mental Health Professionals felt that there is and should be a working relationship between religion and psychotherapy. It was also indicated that if a minister/pastor needs to refer a church member to a psychotherapist that he/she should do so. Sixty seven percent (67.0%) agreed that the minister/paster should make the referral. When asked if psychotherapy, since it deals with the abnormal person, is of little use to the minister/pastor, seventy percent (77.0%) disagreed with the statement that it is of little use. By maintaining a working relationship between religion and psychotherapy, patients can benefit from a more comprehensive treatment approach.

Religious Beliefs in Therapy

The results of the analysis of data relative to religious beliefs in therapy are shown in Table 6.

Research Question Four

Do Mental Health Professionals explore the client's religious beliefs during therapy?

Table 6

Religious beliefs in therapy
(N=40)

ITEM(S)	DESCRIPTION		RESPONSE PATTERN YES	NO
4	Have your clients ever expressed his/her religious beliefs or practice in therapy?	f	32	8
		%	80	20.0
6	Have you ever explored with your client(s) his/her religious practices or beliefs?	f	30	10
		%	75.0	25.0
7	Did it make you uncomfortble dealing with religious belief(s) or practices?	f	20	20
		%	50	50
8	Would you ever seek the assistance of a priest/minister in order to aid your client?	f	35	5
		%	87.5	12.5
11	If a client requests your assistance with a pastor or minister, would you or have you declined?	f	7	33
		%	17.5	32.5

Source: The Relation Between Religion and Psychiatry Scale

Table 6 shows the result of the data analysis related to the percen-

tage of those Mental Health Professionals who explored the client's religious beliefs during therapy. A significant number eighty percent (80.0%) strongly indicated that they have explored with their client(s) his/her religious beliefs. When asked why they explored the client's religious beliefs, it was stated that this was done in order to be able to understand the client(s) better. Further analysis of the data indicated fifty percent (50.0%) of the paticipants did not feel uncomfortable dealing with the religious belief(s) or practice(s).

Research question four comprising the category of religious beliefs in therapy indicated that seventy five percent (75.0%) of the Mental Health Professionals have explored with client(s) his/her religious practices of beliefs. Eighty percent (80.0%) indicated their acceptance of the client's religious beliefs. Eighty seven percent (87.0%) indicated that they would seek the assistance of a minister/pastor in order to aid their client(s). Mental Health Professionals indicated that they would be open to and interested in the client's religious beliefs.

Understanding Client's Culture in Therapy

The results of the analysis of data relative to understanding client's culture in therapy are shown in Table 7.

Research Question Five:

Do Mental Health Professionals believe that understanding a client's culture is an important factor in therapy?

Table 7

Cross-Cultural Training in Therapy
(N=40)

ITEM (S)	DESCRIPTION		RESPONSE PATTERN SA	A	UNDECIDED	DA	SDA
17	Cross-cultural training is essential in Psychotherapy.	f	5	20	9	4	2
		%	12.5	50	22.5	10.0	5.0
33	Understanding the culture and religion of a client is essential in treatment.	f	14	19	3	1	3
		%	35.0	47.5	7.5	2.5	7.5
39	Mental Health Professionals should receive cross-cultural training when working in a cultural area.	f	10	20	8	2	0
		%	25.0	50.0	20.0	5.0	0.0

Source: The Relation Between Religion and Psychiatry Scale.

Table 7 shows the results of the data analysis related to the difference between the percentage concerning understanding client's culture in therapy. Ninety-two percent (92.5%) of the participants strongly agreed that understanding the culture and religion is essential in treatment.

Summary

The findings relative to research question five revealed that there is a strong agreement for understanding a client's culture and religion in therapy. The participants were also asked if cross-cultural training is essential in psychotherapy. Fifty percent (50.0%) agreed that training is important. Further analysis of these data revealed that Mental Health Professionals should receive cross-cultural training when working in a highly sensitive cultural area. Over fifty percent were in favor of such training.

Discussion

Authorities in the field of cross-cultural training recognized that training was definitely lacking in the helping profession. The literature related to this study also revealed that training is needed in cross-cultural and religion when providing services in a culturally sensitive area. The findings in this study support the literature in these areas. Research question one was concerned with whether or not Mental Health Professionals were trained to deal effectively with the issue of strong Religious Beliefs when the issue surfaced during therapy. Fifty percent (50.0%) of the participants in the study agreed that the training was essential in psychotherapy. Further findings indicated over sixty five percent (65.0%) of the participants were not trained in cross-cultural counseling and therapy. This was directly in

line with the reports of authorities in the literature who found a need for and a lack among Mental Health Professionals for training in cross-cultural issues. The participants indicated in general, that a working relationship between Religion and Psychotherapy is important. Here too the literature was supportive. Forty percent (40.0%) agreed that religion and psychotherapy were compatible. Authorities in the field strongly felt that religion and psychotherapy should not be seen as separate but must maintain a working relationship in order to provide effective therapy to clients. Religion is the source of values to most clients. Finding out about client's religion should be looked upon as being important in therapy.

Mental Health Professionals indicated that they explored the client's religious beliefs during therapy. Over seventy five percent (75.0%) of the participants explored the clients's religious beliefs during therapy. These findings were supportive of the findings of the authorities in the literature. The literature also noted that Mental Health Professionals felt comfortable exploring client's religious beliefs/practices. From the results of this study it appeared that if Mental Health Professionals needed the assistance of a priest/pastor that they would not hesitate to obtain it. There was no evidence to support findings in the literature which indicated that Mental Health Professionals hold traditional Religious beliefs/values. Over fifty-two percent of the participants in this study report holding traditional Religious beliefs/values.

The analysis of data related to the area of understanding a client's

culture revealed that forty seven percent (47.0%) of the participants saw it as being important in therapy. The literature also reported that sensitivity, understanding and competence in multicultural contexts are important for both the client and the clinician. Again, the results of this study supported the authorities assumptions about the need for cross-cultural training.

Chapter V

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

A recapitulation of the study is described in this chapter. It is followed by the conclusions, implications and recommendations that are relevant to this study.

Purpose of the Study

The purpose of this study was to evaluate the awareness of Mental Health Professionals' knowledge of Black Islanders' religious beliefs.

Research Questions

The five research questions that were addressed are as follows: Research question number one indicated that Mental Health Professionals are not trained to deal effectively with the issue of strong religious beliefs when issues surface in therapy. Research question number two inquired as to whether or not Mental Health Professionals held traditional religious values or beliefs. Research question number three inquired as to whether or not Mental Health Professionals feel that there is a working relationship between religion and psychotherapy. Research question number four inquired as to whether or not Mental health Professionals explore the client's religious beliefs in therapy.

Research question number five inquired as to whether or not Mental Health Professionals believe that an understanding of a client's culture is an important factor in therapy.

Conceptual Framework

The System Theory was used to describe and analyze human behavior. The individual and his mental health are viewed as a system of actions continuously interacting with self and environment. Who a person is can best be explained by where he/she came from.

Significance of Study

This study was significant in providing statistical data, and pertinent information to psychologists, social workers, psychotherapists, counselors, researchers and educators. In addition, it could assist mental health professionals in providing better services to their clients when strongly held religious beliefs are involved. It could provide the higher education system with empirical data that can assist in the addition of subjects relevant to the social work curriculum. Being able to assist mental health professionals with information about how their values, beliefs attitude and behavior can interface with their client's values and beliefs were significant for this study.

It can provide a better understanding by mental health professionals as to why religion is important to some Black therapists. It will also assist in increasing awareness of stereotyped attitudes about clients with strong religious beliefs. Finally, it provides further information to those mental health professionals who are confronted with strong religious beliefs in therapy.

Definition of Terms

The terms which were of significance to this study were operationally defined as follows:

(1) Attitudes - are the scores that were obtained from RTOS, The Religious Scale, and RBRPS instruments. Scales were designed to assess participations attitudes about religion.

(2) Behaviors - are the scores that were obtained from the RTOS, The Religion Scale and RBRPS instrument Scale, that are designed to assess participants behavior towards religious clients.

(3) Mental Health Professionals - are those selected to participate in this study, who maybe categorized as one of the following: Master's and Bachelor's level social workers, Doctorate and Master's level psychologists, psychiatrists, medical interns, Master's and Bachelor level nurses and licensed Practical nurses.

(4) Black Islander clients - are those clients who are receiving services at the Division of Mental Health in St. Thomas Virgin Islands.

(5) Values - are scores that were obtained from the RTOS, The Religion Scale and the RBRPS Scale were designed to assess participants values about religion.

Review of the Literature

The review of the literature related to this study consisted of four sections. Section one described the characteristics of mental health professionals and the Virgin Islands. Section two addressed the cross-cultural training of mental health professionals. Section three assessed the values and religious beliefs of clients and section four explained cultural perspective in therapy.

Methodology

The methodology and procedural steps that were used to carry out the research study consisted of the following: The survey procedures were employed to determine the current status of phenomena. The population for this study consisted of 40 Mental Health Professionals. Three instruments were administered in this study, namely the Relation between Religion and Psychiatry Scale (RBRPS), the Religion Scale and the Religious Training and Opinion Survey (RTOS). In order to establish a degree of reliability and validity, a feasibility study was conducted. A panel of three judges was also used to establish validity. Authorization to conduct the study was obtained. An informed consent letter was sent to all participants. A schedule for conducting the interviews was developed and approved. The instruments were administered. The results were analyzed, interpreted and incorporated into the final report.

Statistical Procedure

Simple percents were used to analyze and determine the differences in the response patterns of the group. Tables and charts were used to array data.

Conclusion

The analysis of the data in this study appeared to warrant the following conclusions.

1. When participants were surveyed, the majority were from the United States. They were Black, with a Bachelor's Degree, married and likely to be employed as a nurse. They were reared in a small town and their religious preference was Catholic. The median age was between 40 and 49 years old.

2. The analysis of the training level of the Mental Health professionals indicated a large percent never received training in college or while employed in the area of cross-cultural counseling or therapy.

3. The survey of the issues regarding cross-cultural counseling and religion in therapy indicated aneed for training that will benefit the clientele's treatment outcome. One approach to treatment should be sensitivity and awareness.

4. A large number of the participants agreed that religion and psychotherapy were compatible. Religion and psychotherapy should not be seen as separate, but must maintain a working relationship in order to be an effective therapy. Conscious awareness of client's cultural background can provide a paper perspective for effective treatment.

Implications

Inherent in the conclusions drawn from the finding in this study are implications that:

1. It can feasibly contribute to present existing counseling and therapy methodologies which assist individuals in effectively dealing with cross-cultural issues. There is a lack of cross-cultural training by Mental Health Professionals who work in the culturally sensitive areas.

2. Based on the findings in this study, there appears to be a need to look at the training and orientation of Mental Health Professionals who are planning or presently working in a culturally sensitive area.

3. In light of the growing cultural population of immigrants from third world countries, a need for scientific studies be given to the array of concerns to mental health clients and their culture/religion in particular.

4. Colleges and universities look at their curricula to include a cross-cultural perspective for those students in the helping profession who are planning to work with or are in a culturally sensitive area. The findings can present an opportunity for universities and colleges to begin reassessing their programs for training and educating the helping professionals in cross-cultural issues.

Recommendations for Further Study

On the basis of the implications in this study it is recommended that:

1. More investigations such as the one described need to be conducted in a variety of culturally oriented environment.

2. Similar experimental investigations be designed, implemented and evaluated to determine if helping professionals can effectively address the concerns of mentally ill clients with religious beliefs.

3. A comparitive study be done with mental health systems in the United States and non U.S. territories, to compare cross-cultural approaches in treatment.

4. An extension of this study be conducted and include the attitude of mentally ill clients towards the Mental Health Professionals approach to treatment related to religion and cultural issues.

5. Further studies be done in the Caribbean in order that their individual and unique cultural needs can be met and the professional knowledge required to assist these individuals be socially acceptable by the Caribbean people.

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APPENDICES

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FEASIBILITY STUDY

APPENDIX A

Table II

Results of Ratings from Feasibility Study

PARTICIPANTS	RACE	SEX	ITEMS					
			#1	#2	#3	#4	#5	#6
A	W	M	2	1	2	2	1	2
B	Hisp.	F	2	2	2	2	1	2
C	B	F	1	2	2	2	1	2
D	W	M	1	1	1	2	2	1
E	B	M	2	1	1	2	2	1
F	W	M	2	1	1	1	2	2
G	B	F	2	1	1	2	1	2
H	B	F	1	2	2	1	2	2
I	B	F	1	2	2	3	1	2
MEAN			1.5	1.4	1.5	1.8	1.4	1.7

CODE

1 = I strongly agree with statement

2 = I agree with the statement

3 = I am undecided about the statement

4 = I do not agree with the statement

5 = I strongly disagree with the statement

ORIGINAL INSTRUMENTS

APPENDIX B

RELATION BETWEEN RELIGION AND PSYCHIATRY SCALE

This questionnaire is an attempt to get your opinion on some vital issues. We are interested only in your agreement or disagreement with the following statements, and not in the truth or falsity of them. In some cases you may feel you do not have enough information to make a judgment; in such instances we would like you to make the best judgment possible.

Please read every statement and respond to it in terms of your personal agreement or disagreement according to the following plan:

Strongly agree	Agree	Agree and disagree equally	Disagree	Strongly disagree
A	B	C	D	E

Please circle the letter indicating your choice.

1 A psychiatrist can be effective regardless of his religion.

+ A B C D E

2 There is a close relationship between religious and psychiatric ideals.
3 Psychiatry ignores the supernatural side of man.
4 A psychiatrist makes on feel uncomfortable because he is always analyzing his fellow man.
5 Psychiatry denies free will in man's conduct by its emphasis on unconscious motivations.
6 Parishioners should be referred to a psychiatrist as readily as to another medical specialist.
7 There is no conflict between psychiatry and religion.
8 In our complex society it is essential for the priest to have a thorough knowledge of psychiatry.
9 Current psychiatric practice allows people to express sexual impulses without moral inhibition.
10 Common sense is a fitting substitute for psychiatric knowledge.
11 There is nothing in present day psychiatry that is contrary to Catholic teaching.
12 A good Catholic should never undergo intensive psychiatric analysis.
13 Psychiatry is as important as philosophy in seminary training.
14 Religion and psychiatry are compatible.
15 Psychiatrists are likely to misguide a Catholic when moral problems are involved.
16 Psychiatrists often attempt to take the place of a priest.
17 Psychiatry today is dominated by a materialistic philosophy of man.
18 Psychiatric analysis usually requires too much time for treatment to be recommended to a parishioner.
19 Psychiatrists place an exaggerated emphasis on sex.
20 Psychiatric knowledge is essential in adjusting to life in the

seminary.

21 Psychiatry offers few facts and its teachings are mostly hypothetical and uncertain.

22 The findings of psychiatry should be taught to help the priest in his confessional work.

23 In most cases a parishioner who thinks he needs psychiatric help would do better to improve his religious life.

24 Psychiatry is feared only because it is misunderstood.

25 More consistent agreement among psychiatrists is necessary before their teaching can be brought into the seminary.

26 Too much psychiatry is a bad thing.

27 More emphasis on teaching the findings of pcyhiatry is needed in the seminary curriculum.

28 The present seminary curriculum is too crowded to include more teaching of psychiatric knowledge.

29 In dealing with mentally disturbed individuals psychiatry is essential.

30 Psychiatry because of its exclusive concern with abnormal individuals is of little use to the priest.

31 Psychiatry considers religion a mass delusion to be eliminated through analysis.

32 The psychiatrist's use of electric shock therapy should be condemned.

33 The priest who utilizes psychiatric knowledge in his work is a more effective priest.

34 Psychiatry is unacceptable because it deals too much with the unknown.

35 A priest should not hesitate to refer a parishioner to a psychiatrist.

(+ the same response alternatives are used with all items.)

APPENDIX B

THE RELIGION SCALE

Below is a list of issues concerning religion. Please read all statements very carefully and respond to all of them on the basis of your own true beliefs without consulting any other person. Do this by reading each stqatement and then writing, in the space provided at its left, only one of the following numbers: 0,1,2,3,4. The meaning of these figures is:

0: Strongly Disagree
1: Disagree
2: Undecided
3: Agree
4: Strongly Agree

------ 1 A sound religious faith is the best thing in life.
------ 2 Every school should encourage its students to attend church.
------ 3 People should defend their religion above all other things.
------ 4 People should attend church once a week if possible.
------ 5 Belief in God makes life more meaningful.
------ 6 Every person should give 10 percent of his income to his church.
------ 7 All peole are God's children.
------ 8 People attending church regularly develop a sound philosophy of life.
------ 9 We should always love our enemies.
------ 10 God rewards those who live religiously.
------ 11 Prayer can solve many problems.
------ 12 Every school should have chapel services for its students.
------ 13 There is life after death.
------ 14 People should read the Scriptures at least once a day.
------ 15 Teachers should teach religious ideals in class.
------ 16 Young people should attend Sunday School regularly.
------ 17 People should pray at least once a day.
------ 18 A religious wedding ceremony is better than a civil one.
------ 19 Religious people should try to spread the teachings of the Scriptures.
------ 20 People should say grace at all meals.
------ 21 When a person is planning to be married, he should consult his minister, priest, or rabbi.
------ 22 Delinquency is less common among young peole attending church regularly.
------ 23 What is moral today will always be moral.
------ 24 Children should be brought up religiously.
------ 25 Every person should participate in at least one church activity.

INSTRUMENTS

APPENDIX C

JUDGES RATING SHEET

DIRECTIONS:

Please rate the aspects of the instrument attached based on your years of training and experience in the areas of psychotherapy, culture and religion using the code below.

CODE:

1 = I strongly agree with the statement.
2 = I agree with the statement.
3 = I am undecided about the statement.
4 = I do not agree with the statement.
5 = I strongly disagree with the statement.

----- 1. The format of the inventory is appropriate to the population on which it was designed to be used.

----- 2. The content of the instrument adequately samples the universe of content which might be measured.

----- 3. The content of the instrument appropriately takes into account the vocabulary functioning level of the popoulation on which it is designed to be used.

----- 4. Each item is clearly stated.

----- 5. The directions are clearly stated.

----- 6. The presentation of the items (i.e., use of large letter, arrangement of sections, and order of items) on the instrument is appropriate to the population on which it is to be used.

Comments:

Date

Signature

Position

Institutional Affiliation

APPENDIX C

RELIGIOUS TRAINING AND OPINION SURVEY (RTOS)

Please read each question carefully and respond to all of the items as accurately and truthfully as possible. Do not leave any blanks.

II. Survey Data

1. Have you ever received previous training in religious issues: Yes__ No__ If yes, explain:_____

2. Did your school provide cross culture training: Yes___ No___ If no, explain why you think it is important._____

3. Does your knowledge of religious practices influence your professional practice? Yes___ No___ Not Sure___ If yes, please explain:_____

4. Have your clients ever expressed his/her religious belief(s) or practice in therapy? Yes___ No____

5. If yes, what was your reaction? Specify,_____

6. Have you ever explored with your client(s) his/her religious practices or belief(s)? Yes___ No___ Not Sure___ If yes, please explain why.

7. Did it make you uncomfortable dealing with the religious belief(s) or practices? Yes___ No___ Not Sure____ If either yes or no, please explain._____

8. Would you ever seek the assistance of a priest, pastor or minister in order to aid your client(s)? Yes___ No___ Not Sure If yes or no, please explain._____

9. Was the assistance helpful? Yes____ No____ Not Sure____ How would you describe your feeling when your client(s) informed you of his/her religious belief(s) or practices?

Uninterested	_____
Opposed to the belief(s) or practices	_____
Open and interested	_____
Skeptical	_____
Neutral	_____
Other (Specify)	_____

10 If a client strongly insist that religion plays a great part in his/her life and asks for your opinion and any assistance, do you find yourself:

Giving no opinion	_____
Extremely bias	_____
Extremely pessimistic	_____
Allowing client to decide for himself/herself	_____
Discouraging client to continue to belief in his/her religion	_____
Encouraging the client	_____
Attempting to further evaluate and make comments later	_____
Other (specify)	_____

11. If a client requests your assistance with a pastor or minister, would you or have you declined? Yes____ No____ Not Sure____ If yes, or no, please explain _____
_____
_____

12. Does the mental health professional's religious experience influence their attitudes toward the clients strong religious belief.
Yes____ No____ Unsure____ If yes, explain:_____
_____
_____

THANK YOU AGAIN FOR PARTICIPATING IN THIS STUDY

APPENDIX C

THE RELIGION SCALE

Below is a list of issues concerning religion. Please read all statements very carefully and respond to all of them on the basis of your own true beliefs without consulting any other person. Do this by reading each stqatement and then writing, in the space provided at its left, only one of the following numbers: 1,2,3,4,5. The meaning of these figures is:

1: Strongly Disagree
2: Disagree
3: Undecided
4: Agree
5: Strongly Agree

------ 1 A sound religious faith is the best thing in life.
------ 2 Every school should encourage its students to attend church.
------ 3 People should defend their religion above all other things.
------ 4 People should attend church once a week if possible.
------ 5 Belief in God makes life more meaningful.
------ 6 Every person should give 10 percent of his income to his church.
------ 7 All peole are God's children.
------ 8 People attending church regularly develop a sound philosophy of life.
------ 9 We should always love our enemies.
------ 10 God rewards those who live religiously.
------ 11 Prayer can solve many problems.
------ 12 Every school should have chapel services for its students.
------ 13 There is life after death.
------ 14 People should read the Scriptures at least once a day.
------ 15 Teachers should teach religious ideals in class.
------ 16 Young people should attend Sunday School regularly.
------ 17 People should pray at least once a day.
------ 18 A religious wedding ceremony is better than a civil one.
------ 19 Religious people should try to spread the teachings of the Scriptures.
------ 20 People should say grace at all meals.
------ 21 When a person is planning to be married, he should consult his minister, priest, or rabbi.
------ 22 Delinquency is less common among young peole attending church regularly.
------ 23 What is moral today will always be moral.
------ 24 Children should be brought up religiously.
------ 25 Every person should participate in at least one church activity.

QUESTIONNAIRE APPENDIX C

You are being asked to participate in a study of mental health problems. Your participation will supply valuable information to those responsible for the nation's health. On the following pages you will find a number of statements about health problems. We want to know how much you agree or disagree with each of the statements. To the right of each statement you can find a rating scale.

Place of Birth:_____

Demographic:

1. **Age:**

20-29	___
30-39	___
40-49	___
50-59	___
60 or older	___

2. **Position:**

Psychotherapist	___
Psychologist	___
Psychiatry	___
Nurse	___
Social Worker	___
Other (Specify)	_____

3. **Educational Training:**

Bachelor	___
Masters	___
Speciality	___
Ph.D	___
M.D.	___
Other (Specify)	_____

4. **Have you had professional training in:**

Cross Cultural Counseling	**yes or no**
Value System Theory	**yes or no**
Religion/Philosophy	**yes or no**

5. Length of Clinical Experience In Mental Health Services:

2 years or less	___
2-5 years or less	___
5-10 years	___
10-15 years	___
More than 15 years	___
	___

APPENDIX C

6. Sex: Male _____ Female _____

7. Race:
White ___ Black ___ Hispanic ___ Other (Specify) _____

8. Religion:

Catholic	___	Full Gospel/Charismatic	___
Anglican	___	Latter Day Saints	___
Methodist	___	No Preference	___
Moravian	___	Unknown	___
Lutheran	___	Agnostic	___
Baptist	___	Other (Specify)	___
Protestant	___		

9. Marital Status:

Single	___	Separated	___
Married	___	Widowed	___
Divorced	___		

10. Where were you raised:

Small Town	___	Rural	___
Surburban	___	Mid-size Town	___
Large City	___		

APPENDIX C

Relation Between Religion and Psychiatry Scale (RBRPS)

This questionnaire is an attempt to get your opinion on some vital issues. This researcher is only interested in your agreement or disagreement with the following statements,and not in the truth or falsity of them. In some cases you may feel you do not have enough information to make an objective judgment. Please choose an answer that is most closely in line with your value system. Do not skip any statements.

Please read every statement and respond to it in terms of your personal agreement or disagreement according to the following plan:

CODE	
Strongly agree	1
Agree	2
Agree & Disagree (equally)	3
Disagree	4
Strongly Disagree	5

Please circle the number indicating your choice.

1. There is a close relation between religious and psychological concepts. 1 2 3 4 5
2. Psychotherapy ignores the supernatural side of man. 1 2 3 4 5
3. A Mental Health Professional makes one feel uncomfortable because he or she is always analyzing his/her fellow man. 1 2 3 4 5
4. A Mental Health Professional can be effective regardless of his/he religion. 1 2 3 4 5
5. A Mental Health Professional denies free will in man's conduct by its emphasis on unconscious motivations. 1 2 3 4 5
6. A religious person should be referred to a Mental Health

Professional as readily as to another medical specialist.
1 2 3 4 5

7. There is no conflict between psychotherapy and religion. 1 2 3 4 5

8. In our complex society, it is essential for the minister/pastor to have a thorough knowledge of psychotherapy. 1 2 3 4 5

9. Current psychological practice allows people to express sexual impulses without moral inhibition. 1 2 3 4 5

10. Common sense is a fitting substitute for psychological knowledge. 1 2 3 4 5

11. Culture plays a significant role in religion. 1 2 3 4 5

12. A good Christian should never undergo intensive psychotherapy. 1 2 3 4 5

13. There is nothing in present day psychotherapy that is contrary to religious teaching. 1 2 3 4 5

14. Religion and psychotherapy are compatible. 1 2 3 4 5

15. Training in religion is essential in order to provide proper assessment. 1 2 3 4 5

16. Mental Health professionals are likely to misguide religious clients when moral problems are involved. 1 2 3 4 5

17. Cross-cultural training is essential psychotherapy. 1 2 3 4 5

18. Mental Health Professional often attempts to take the role of a pastor/minister. 1 2 3 4 5

19. Psychotherapy today is dominated by a materialistic philosophy of man. 1 2 3 4 5

20. Psychotherapy usually requires too much time for treatment to be recommended to a religious person. 1 2 3 4 5

21. Psychological knowledge is essential in adjusting to life in the church. 1 2 3 4 5

22. Psychotherapy offers few facts and its teachings are mostly hypothetical and uncertain. 1 2 3 4 5

23. The findings of psychotherapy should be taught to help the pastor/minister in his/her church business. 1 2 3 4 5

24. A value system is derived from one's culture. 1 2 3 4 5

25. In most cases a religious person who thinks he needs psychotherapy would do better to improve his/her religious life. 1 2 3 4 5

26. Psychotherapy is feared only because it is misunderstood.
1 2 3 4 5

27. More consistent agreement around the area of psychotherapy is necessary before its teaching can be brought into the church.
1 2 3 4 5

28. Too much psychotherapy is a bad thing. 1 2 3 4 5

29. Religion is feared only because it is misunderstood. 1 2 3 4 5

30 The present Christian school curriculum is too crowded to include more teaching of psychological knowledge. 1 2 3 4 5

31. In dealing with mentally disturbed individuals, psychotherapy is essential. 1 2 3 4 5

32. Psychotherapy, because of its exclusive concern with abnormal individuals is of little use to the minister/pastor. 1 2 3 4 5

33. Understanding the culture and religion of a client is essential in treatment. 1 2 3 4 5

34. Psychotherapy considers religion as mass delusion to be eliminated through analysis. 1 2 3 4 5

35. The psychotherapist's use of electric shock therapy should be condemned. 1 2 3 4 5

36. The pastor/minister who utilizes psychological knowledge in his/her work is a more effective pastor. 1 2 3 4 5

37. Psychotherapy is unacceptable because it deals too much with the unknown. 1 2 3 4 5

38. A pastor/minister should not hesitate to refer a church member to a psychotherapist. 1 2 3 4 5

39. Mental Health Professionals should receive cross-cultural training when working in a cultural area. 1 2 3 4 5

40. In dealing with mentally disturbed individuals, religion is essential. 1 2 3 4 5

DATA SHEET

DATA SHEET

APPENDIX D

#	RAW SCORES															
1	95	113	11	11	11	O	I	C	R	23	40-49	V	1	20	5
2	106	124	10	10	10	O	I	C	S	23	40-49	T	1	19	5
3	111	117	11	11	11	M	H	E	S	23	40-49	W	1	15	7
4	100	112	10	11	11	N	J	C	S	23	30-39	U	2	15	5
5	86	112	11	11	11	N	J	A	R	23	20-29	U	2	22	5
6	89	115	10	10	11	N	J	B	S	23	20-29	V	1	15	5
7	92	111	11	11	11	M	H	C	S	24	50-59	T	4	12	7
8	87	119	11	11	11	M	H	D	S	23	30-39	T	1	19	8
9	88	123	11	11	11	N	H	B	S	23	40-49	W	1	15	5
10	86	126	10	11	11	P	H	E	S	23	40-49	T	1	12	7
11	91	115	10	10	11	O	I	B	S	23	40-49	W	1	19	7
12	70	103	10	11	11	N	H	A	S	24	40-49	T	1	12	5
13	85	112	11	11	11	N	H	E	S	24	40-49	T	2	17	8
14	87	110	10	11	10	O	G	E	S	25	50-59	X	3	17	6
15	78	126	10	10	10	Q	F	D	S	23	60 or older	X	4	13	6
16	89	125	11	11	11	N	J	B	S	23	20-29	T	1	12	5
17	54	143	11	11	11	N	J	C	S	23	40-49	U	1	21	5
18	95	105	11	11	10	O	I	E	S	23	40-49	U	3	13	5
19	76	109	11	11	11	L	J	D	S	23	30-39	T	1	19	7
20	79	81	10	11	11	Q	F	E	R	24	60 older	T	1	26	9
21	79	95	10	10	10	P	G	E	S	23	50-59	T	3	21	6
22	89	115	10	10	10	M	J	D	R	23	40-49	T	1	16	7
23	87	135	10	10	10	N	J	C	S	24	50-59	T	3	17	9
24	93	106	11	11	11	N	H	B	S	24	40-49	T	1	12	5
25	83	128	11	11	11	M	H	E	S	23	40-49	U	1	13	-
26	93	117	10	10	10	O	I	E	R	23	40-49	T	1	27	5
27	92	103	11	11	11	L	J	C	S	23	40-49	U	3	12	7
28	80	118	10	11	10	O	I	E	R	23	50-59	T	1	18	7
29	100	117	11	11	11	L	J	E	R	23	50-59	U	3	15	5
30	112	116	11	11	11	L	K	D	S	23	50-59	V	3	14	5
31	103	115	11	11	11	L	H	A	S	24	40-49	V	2	12	7
32	84	128	11	11	11	O	I	D	S	223	40-49	T	1	19	8
33	58	124	10	11	11	N	H	D	S	24	50-59	T	3	13	8
34	89	115	11	11	11	M	J	E	S	23	50-59	W	2	15	5
35	99	120	11	10	11	O	I	C	S	23	30-39	U	1	12	5
36	76	128	10	10	11	N	H	C	S	24	40-49	T	3	13	6
37	79	113	10	10	10	O	I	A	S	24	40-49	T 1	1	14	6
38	84	113	11	11	11	N	J	D	R	24	3039	T	2	12	5
39	73	113	11	11	11	N	H	D	S	23	60-	W	1	15	9
40	68	122	11	11	11	O	J	B	S	23	60-	T	1	12	6

TOTAL=3975 5738

MEAN=47.925 104.975

SD= 12.089 11.690

INFORMATION CODE

LENGTH OF EMPLOYMENT
2 years or less....A
2-5 years.....B
5-10 years.....C
10-15 years.....D
more than 15 years.E

PROFESSION
PSYCHIATRIST.....F
PSYCHOLOGIST.....G
NURSE.....H

MARITAL STATUS
MARRIED.....1
SINGLE.....2
DIVORCED.....3
WIDOW.....4

PROF. CONT.
SOCIAL WORKER.....I
MENTAL HEALTH WORKER I & II.....J
AID.....K

EDUCATIONAL TRAINING
HIGH SCHOOL.....L
A.A.....M
BACHELOR.....N
MASTERS.....O
Ph.D.....P
M.D.....Q

PLACE WHERE REARED
SMALL TOWN.....5
LARGE CITY.....6
MIDSIZE.....7
SUBURBAN.....8
RURAL.....9

PROFESSIONAL TRAINING
YES.....10
NO.....11

SEX
MALE.....R
FEMALE...S

PLACE OF BIRTH
UNITED STATES...T
U.S.VIRGIN IS...U
BRITISH, V.I....V
WEST INDIES.....W
EUROPE.....X
CANADA.....Y

RACE
BLACK.....23
WHITE.....24
HISPANIC.....25

RELIGION PREFERENCE
CATHOLIC.....12
LUTHERAN.....13
METHODIST.....14
ANGLICAN.....15
ISLAM.....16
BAHAI.....17
SEVEN DAY ADVENT.18
BAPTIST.....19
PROTESTANT.....20
NO PREFERENCE....21
FULL GOSPEL.....22
MORAVAIN.....26
ISRAELITE.....27

LETTER(S)

APPENDIX E

Date:_____

Dear_____:

You have been selected to participate in a research project that is being conducted under the direction of my advisor at Atlanta University's School of Social Work. The purpose of this research is to look at attitude and behavior of Mental Health professionals towards Black, Islander client religious beliefs. An additional objective is to look at educational and training backgrounds of the participants.

Please let me assure you that any results relating to you personally will be held in the strictest of confidence.

In order to assure this level of confidentiality, numerical codes will be used in place of names for all participants in the research. These codes will be used only to assist in the interpretation of any significant data generated by the research.

Thank you for your support in this project as without your participation, it would not be possible. Please complete the bottom portion of this page to indicate your consent for participation in this project.

Sincerely,

Sylvia Buntin-Simmons

_____Yes, I, _____, do consent to participate in the
(please print)
research project as described above.

_____No, I, _____, do not consent to participate in the
(please print)
research project as described above.

_____ _____
(Participants Signature) (Date)

APPENDIX E

October 31, 1988

Dear

RE: Rating

Thank you for agreeing to serve as a judge of the rating panel for the instruments I've requeted that you review. Enclosed, you will find a copy of three instruments along with a rating sheet. If the rating sheet does not provide sufficient space for you to record your comments, feel free to use additional paper.

As time is essential, I would greatly appreciate it if you would please complete the rating sheet as soon as possible. I will be contacting you in about 5 days to arrange to pick up the rating sheet and the testing instruments.

I would like to thank you in advance for your assistance. I appreciate your willing cooperation.

Sincerely,

Sylvia M. Buntin-Simmons

APPENDIX E

August 15, 1988

Dr. G. Rita Dudley, Asst. Commissioner
Department of Health
Commissioner's Office
St. Thomas, USVI 00801

Dear Dr. Dudley:

Pursuant to our recent telephone conversation, I am taking this opportunity to write to you and formally request your consent to utilize the staff of the Division of Mental Health to assist me in gathering data pertinent to the completion of my doctoral dissertation for my doctorate degree in social work.

I am a native Virgin Islander, who has worked with the Division of Mental Health in St. Thomas Virgin Islands from 1982 to 1985. I resigned in 1985 to return to school in Atlanta, GA. While employed with the division, I progressed to the position of Supervisor/Mental Health Worker III in the Longterm Care program at the Knud Hansen Hospital.

During my tenure with the department I became interested in the attitudes of therapists towards clients with strong religious beliefs. The topic of my dissertation is, "The influence of attitudes and behaviors of mental health professionals toward clients with strong religious beliefs."

I am scheduled to begin my final year in the doctoral program at Atlanta University School of Social Work in September and also working on a Masters Degree in Public Administration at the same time.

Presently, I am working on my proposal and I am scheduled to defend the proposal in October, 1988, at which time I will be forwarding a copy of my proposal to you.

I am trying to schedule a trip home to the Virgin Islands in December so that I can administer the questionnaires and also conduct random interviewing.

The study will also address the cross cultural approach in treatments.

I will certainly appreciate any assistance that you might be able to give me and I look forward to meeting with you when I arrive in St. Thomas.

Should you need to contact me to confirm or question anything that I am proposing to do upon my arrival, please feel free to call me at the following number or to write me at the address provided.

Sylvia M.B. Simmons
7085 Green Bower Lane
College Park, GA. 30349
(404) 996-8751

I wish to take this opportunity to thank you in advance for any assistance you may render and also for taking time out to talk with me over the telephone.

Sincerely,

Sylvia Simmons, MSW

APPENDIX E

January 18, 1989

Mr. Wayne Langford, Director
Community Support Program
Psychiatric Unit
Grady Hospital
Atlanta, Georgia

Dear Mr. Langford,

I would first of all like to take this opportunity to thank you for your assistance as well as that of your staff in taking time out from your busy schedule to complete my research questionnaire. Secondly, I am taking this opportunity to answer the questions that you raised regarding my questionnaire and study.

The purpose of this research project is to look at the attitude and behavior of Mental Health professionals towards black clients of Caribbean origin with strong religious beliefs. An additional objective is to look at the educational and training background of the participants in the project, namely:

1. Are Mental Health professionals trained to deal effectively with the issue of strong religious beliefs when such issues surface during therapy?

2. Do Mental Health professionals consciously or unconsciously impose their values and/or religious beliefs on their client(s) during therapy?

3. Do Mental Health professinals mis-diagnose culturely based religious beliefs as a form of mental illness?

4. Do current and prior religious experiences of the Mental Health professional(s) influence their attitude towards the client's strongly held religious beliefs?

5. Are Mental Health professionals educated to the cultural background of their clients?

Please be assured that any results relating to either you personally or your staff will be held in the strictest of confidence. Numerical codes will be used in place of the names of those persons who participated in this research project.

Thank you once again for your support in this project for without it, completion would not be possible. Please convey my appreciation and thanks to your staff also.

Sincerely yours,

Sylvia M.B. Simmons,MSW

APPENDIX E

December 28, 1988

Dr. Gertrude R. Dudley
Assistant Commissioner
Department of Health
St. Thomas Hospital
Sugar Estate
St. Thomas, V.I. 00802

Dear Dr. Dudley:

I wish to express my appreciation and heartfelt thanks for your assistance, as well as that of your staff, in completing the research questionnaire I submitted to you. The information obtained will greatly assist me in the accomplishment of my doctorate requirements.

Please convey my appreciation and thanks to your staff.

Have a Happy and Prosperous New Year.

Respectfully yours,

Sylvia Buntin Simmons, MSW

December 28, 1988

Ms. Althelia Johnson
Director of Medical Social Services
Department of Health
St. Thomas Hospital
Sugar Estate
St. Thomas, United States V.I.
00802

Dear Ms. Johnson:

I wish to express my appreciation and heartfelt thanks for your assistance, as well as that of your staff, in completing the research questionnaire I submitted to you. The information obtained will greatly assist me in the accomplishment of my doctorate requirements.

Please convey my appreciation and thanks to your staff.

Have a Happy and Prosperous New Year.

Respectfully yours,

Sylvia Buntin Simmons, MSW

December 28, 1988

Mr. Laurent Javois
Administrator of Mental Health Services
& Program Evaluation
Department of Health
Mental Health Division
Estate Diamond Ruby #6&7
Christiansted, St. Croix 00820

Dear Mr. Javois:

I wish to express my appreciation and heartfelt thanks for your assistance, as well as that of your staff, in completing the research questionnaire I submitted to you. The information obtained will greatly assist me in the accomplishment of my doctorate requirements.

Please convey my appreciation and thanks to your staff.

Have a Happy and Prosperous New Year.

Respectfully yours,

Sylvia Buntin Simmons, MSW

GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF HEALTH

OFFICE OF
THE COMMISSIONER

Charlotte Amalie
St. Thomas, Virgin Islands 00801

December 19, 1988

APPENDIX E

PHPP
Mental Health Division
Department of Health
St. Thomas, Virgin Islands 00801

Dear Staff:

Ms. Sylvia Simmons is a former social Worker Supervisor with the Department of Mental Health. She is currently completing her doctoral dissertation at Atlanta University.

She has been granted permission by my office to carry out this survey of mental health professionals towards clients' religious beliefs. Please complete the brief questionnaires which she is utilizing and give her your full cooperation. This study and the results will be kept in strict confidentiality.

Thank you for your assistance in this matter.

Sincerely,

G. Rita Dudley, Ph.D.,M.P.H.
Assistant Commissioner